IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
KARL B. KURTZ – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7000 1670 0011 3314 9054

August 18, 2006

Gail Goglia, Administrator
Blaine Manor
706 South Main Street, P.O. Box 927
Hailey, ID 83333

Provider #: 135069

Dear Ms. Goglia:

On **August 9, 2006**, a fire safety survey was conducted at Blaine Manor by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency in your facility to be a pattern of deficiencies that constitute no actual harm, but have potential for more than minimal harm and are not an immediate jeopardy, as evidenced by the attached CMS Form 2567L whereby corrections are required.

Enclosed is a Statement of Deficiencies/Plan of Correction, CMS Form 2567L, listing Medicare/Medicaid deficiencies, and a similar form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **Please provide ONLY ONE completion date for each Federal/State Tag in column X5 (Complete Date), to signify when you allege that each tag will be back in compliance. NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Date Certain" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign both the CMS Form 2567L and State Statement of Deficiencies, in the spaces provided, and return the originals to this office.**

Your Plan of Correction (PoC) for the deficiencies must be submitted by **August 31, 2006**. Failure to submit an acceptable PoC by **August 31, 2006**, may result in the imposition of civil monetary penalties by **September 20, 2006**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **September 13, 2006 (Date Certain)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **September 13, 2006**. A change in the seriousness of the deficiencies on **September 13, 2006**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **September 13, 2006** includes the following:

Denial of payment for new admissions effective **November 9, 2006**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **February 9, 2007**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact me with your written credible allegation of compliance at the following address:

Bureau of Facility Standards — DHW

3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036

If you choose and so indicate, the POC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **August 9, 2006** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR 488.331, you have the opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send a written request which states the specific deficiencies being disputed, and explains why you are disputing those deficiencies. This request must be received by **August 31, 2006**.

All required information should be as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach1.pdf

If your request for informal dispute resolution is received after **August 31, 2006**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

MARK P. GRIMES
Supervisor
Facility Fire Safety and Construction

MPG/dmj

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135069	A. BUILDING 02 - ENTIRE BLDG B. WING _____	08/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLAINE MANOR	PO BOX 927 HAILEY, ID 83333

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The facility is a single story, type V(111) construction. It is fully sprinklered and has full smoke detection coverage. It has class A interior finish and piped in oxygen. The facility was built in 1982 and currently is licensed for 25 SNF/NF beds. The following deficiencies were cited at the above facility during the annual Fire/Life Safety survey conducted on 9 August, 2006. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, adopted 11 March, 2003. In accordance with CFR 42, 483.70. The Survey was conducted by: Chris Laumann, Health Facility Surveyor .	K 000	See attached POCs RECEIVED AUG 25 2006 FACILITY STANDARDS	
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by:	K 025		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Gail Gogha	Administrator	08/24/06

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 025	Continued From page 1 Based on observation it was determined that the facility failed to maintain the ceilings within the corridor in a state to resist the passage of smoke. This had the potential to effect all residents and staff in one, of the three smoke compartments. The facility had a census of 20 residents Findings include: 1.) During a facility tour on 9 August, 2006 at 2:25 PM, it was observed that a finger width gap around a sprinkler head located within the "long" hallway adjacent to room 42. This compromised the required half hour resistive rating of the corridor. In accordance with NFPA 101 Life Safety Code section 8.3, smoke barriers are required to be constructed to provide at least a one half hour fire resistance rating. Observations were witnessed and noted by surveyor and facility maintenance supervisor.	K 025		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observations it was determined that the facility failed to ensure compliance with electrical safety regulations. One of twenty residents was in danger of electrocution and exposure to fire. Findings include:	K 147		

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K 147	Continued From page 2 1. Observation on 9 August, 2006 at 2:00 PM, revealed a broken electrical outlet in room 42, exposing live wires. All finding were observed and noted by surveyor and maintenance supervisor.	K 147		

Bureau of Facility Standards

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C 000	INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The facility is a single story, type V(111) construction. It is fully sprinklered and has full smoke detection coverage. It has class A interior finish and piped in oxygen. The facility was built in 1982 and currently is licensed for 25 SNF/NF beds. The following deficiencies were cited at the above facility during the annual Fire/Life Safety survey conducted on 9 August, 2006. The facility was surveyed under IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities. The Survey was conducted by: Chris Laumann, Health Facility Surveyor	C 000	See attached POCs RECEIVED AUG 25 2006 FACILITY STANDARDS	
C 230	02.106,02,b b. Existing facilities licensed prior to the effective date of these rules, regulations and minimum standards and in compliance with a previous edition of the Life Safety Code may continue to comply with the edition in force at that time. This Rule is not met as evidenced by: : Refer to federal tags K 0025 as it relates to	C 230		

Bureau of Facility Standards

Gail Goglia — Administrator — 08/24/06

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

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C 230	Continued From page 1 smoke walls and K 0147 as it relates to electrical code requirements. All federal K tags are documented on CMS-2567.	C 230		

BLAINE MANOR
PLAN OF CORRECTION
FIRE SAFETY SURVEY – AUGUST 9, 2006

August 24, 3006

K025, C230

All residents and staff have the potential to be affected by this issue and the plan of correction.

Plan of Correction

The ring around the identified sprinkler head was replaced.

The Maintenance Supervisor will conduct daily "walk-through" to identify and correct any sprinkler head issues.

Staff will be reminded by written memorandum and quarterly safety in-services to report any sprinkler head issues.

The Maintenance Supervisor will keep a record of all sprinkler head repairs (work order and log).

Monitoring

The Maintenance Supervisor will monitor daily and report findings to the Performance Improvement/Quality Assurance Committee.

Completion Date:

August 10, 2006.

BLAINE MANOR
FIRE SAFETY SURVEY – AUGUST 9, 2006

August 24, 2006

K147

All residents and staff have the potential to be affected by this issue and the plan of correction.

Plan of Correction

The broken electrical outlet cover plate was replaced.

The Maintenance Supervisor will conduct a daily "walk through" to identify and correct any electrical issues, including broken/cracked/loose electrical outlet cover plates.

Staff will be reminded by written memorandum and quarterly safety in-services to report any electrical issues, including broken/cracked/loose electrical cover plates.

The Maintenance Supervisor will keep a record of all electrical cover plate repairs (work order and log).

Monitoring

The Maintenance Supervisor will monitor daily and report findings to the Performance Improvement/Quality Assurance Committee.

Completion Date

August 10, 2006

BLAINE MANOR - ACTION PLAN

Initiative Title: Plan of Correction K 025 and K 147 **Date:** 8/10/06

Indicator Addressed: Meeting Life Safety Code Standards Expect 100% Compliance

Where/How will this Action Plan Results be reported? QA/PI Committee

Action Plan developed by: D. Hennefer, Maint. Super. **Action Plan reviewed by:** G. Goglia, Administrator

Specific Steps	WHO Will BE Responsible for Step?	WHEN is this Expected to be Complete?	How does this Dovetail with Existing Activity?
Identify and repair issues with sprinkler heads and elecrical cover plates	Maintenance Super.	8/10/06 and immed. when identified.	Part of preventative maintennce program.
Daily "walk-through" to identify and correct any problems.	Maintenance Super.	8/10/06 and daily	Part of preventative maintenance program
Memos to all staff re fire and elecrical safety	Maintenance Super. Administrator	Posted 8/10/06 Insert in next payroll envelope	Part of preventative maintenance program
Quarterly in-service on fire and safety	Maintenance Super.	Fourth quarter 2006 and on-going	Part of fire and safety in-service program
Documentation of all repairs	Maintenance Super.	8/10/06 and on-going	Part of preventative maintenance program
Monitoring and reporting to PI/QA Committee	Maintenance Super.	Fourth quarter 2006 and on-going	Part of preventative maintenance and PI/ QA programs